Primary Care Cures

Episode 118: Clinton Phillips

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

Value-based care. Well, it's the only way to go since fee-for-service and since volume, not outcomes, or is it? Three points. Number one, every CMS study shows zero to negligible savings of value-based care over fee-for-service. Number two, four CMS experts who were on a panel a couple of years ago, boring their audience to death, mostly PCPs, at Wharton.

Ron Barshop:

And then it was time for Q and A, and one of our guests, Dr. Marion Mass, was asking them if there are any savings or improved outcomes for value-based care. And these are the four experts at CMS. The crickets ensued, no answer for a couple of minutes. All that sound and fury it costs for what?

Ron Barshop:

A Blue Cross CEO, point number three, admitted recently that value-based care not only offers no savings over fee-for-service to them, but it was also a defect of 90% effectively like fee-for-service. What is he saying? We'll get into that in a second.

Ron Barshop:

What I'd like to do is not really whitewash something this big as all noise, because I do believe value-based care is effective in some measures, if the ACO or the docs go, what's called full-risk, most do not. 10 MED goes full risk and maybe 5% of the others bragging about value-based care as if it's a foregone conclusion, do not go full-based risk.

Ron Barshop:

So it's not settled like Betamax over VHS or Coke over Pepsi. And you know who has the best chance of actually winning? Our guests today. None of the above. The big winner has to show five true winners in the game of life, the game of healthcare to create five things.

Ron Barshop:

Number one, lower costs, number two, better outcomes, then happy docs, number three, happy patients and happy payers numbers four and five. And I just described direct contracting. It's maybe 25 million patients. Couple of weeks ago I thought it was 15 million, but I started doing the math and it's much higher, especially when you include guests like today's.

Ron Barshop:

So it's maybe five to 15,000 providers, nobody really knows. It's maybe 25 million patients, nobody really knows because there's no association doing a head count, but let me give you some math. Today's guest 13 million patients that are directly contracted with employers, self-insured and then we have another guest Premise Health, who has 11 million.

Ron Barshop:

So that's 24 million. And then when you start throwing in Crossover, NextEra and some of the others who have been on our show, you're talking probably close to 28 million. So, there are dozens I don't even know about that. They are not even on my radar, that are in virtual and direct primary care.

Ron Barshop:

With offerings and two even went public last year. So there are dozens that offer employers paid care on a monthly subscription basis like today's guest. So, is value-based care mostly fluff and glitter and stuffing? I think so. It's not real meat in producing those five winners. I think the doctors that subscribed to them do very well, but I'm not sure everybody else wins.

Ron Barshop:

So let's go ahead and welcome back a gent from Austin who opened my eyes to how important virtual primary care is, and is among the largest, as I said, with 13 million patients served one year ago when we spoke. He also has one in three Fortune 1000 clients as his winners, pretty impressive. You certainly heard of Teledoc, but maybe not Medici and its CEO Clinton Phillips, who we are glad to have back on the show. Welcome back.

Clinton Philips:

Thank you, Ron. It's awesome to be back on the show and talking about what is hugely passionate about. So, I love the cause, but you have taken on and I'm very keen to dive into this subject.

Ron Barshop:

Why don't people have an association in your world? Why has nobody created an association, so you can band together and share best practices like other associations do?

Clinton Philips:

That's an excellent question. I think there are associations nibbling around the edges and there are Family Practice Associations and Primary Care Associations, but I think there really needs to be... I think it hasn't been settled yet where the individual doctors moving to DPC type of models or it's going to be the bigger businesses, the One Medicals, the Crossovers, the larger groups that

are going to corral the doctors together. And so, I think there's still uncertainty, whether it's a more of a macro-play or a more of a micro-play.

Ron Barshop:

Well, let's talk about your number since it's been a year. You've had nothing short of a pandemic, which has driven so much into virtual care, which is your sweet spot. So, you were at 13 million in March, a year ago. What are we looking like in May of 2021?

Clinton Philips:

We have seen a big increase in the numbers of consults. We haven't really pushed for an increase in covered lives. So driving actual utilization of the virtual care offerings has been what's really important. Over the last year, I sold 2nd.MD, which was acquired by Accolade. And 2nd.MD was where we had the majority of our patients that worked at large companies.

Clinton Philips:

So we had, as you mentioned earlier, a third of the Fortune 100 that were using 2nd.MD to be able to manage complexity and offer direct care for specialty types of care. And Medici saw tremendous growth in the movement from doctors becoming very comfortable with virtual care.

Clinton Philips:

For years, we've been knocking on doctor's doors saying, "Virtual care is coming, it's coming, it's coming." And they kept saying, "Oh, you can't do quality. No, I don't think I'll ever move in that direction." And instead of the majority of doctors doing virtual care in 2024, all of a sudden, that moved a few years sooner. And in 2020, 2021, there are many doctors now who do more virtual care today, than they do in-person care.

Clinton Philips:

On the Medici platform, we had over 4,000 doctors using Medici to deliver care to their patients. And it was incredible to see doctors who went from saying, "I'll never do this," say, "I have to do this today." And to see them pleasantly surprised that they can actually have great relationship, they can have great engagement, they can deliver really high quality care, was a great learning curve for us.

Clinton Philips:

And I love as you mentioned those things, cost, outcomes, happy patients, happy doctors, we trying to live in those areas. Maybe we haven't cared as much about happy payers, but we have really cared about seeing that this is something sustainable for our doctors and patients were a lot easier to convince than the doctors.

Ron Barshop:

We had a guest on two weeks ago and he said that utilization is up 40%. What was your utilization up thus last year?

Clinton Philips:

About 400%.

Ron Barshop:

Wow. That's amazing.

Clinton Philips:

That happened in a month. And then, pretty much held from [scale up 00:07:41] in March, April next year. March, April, last year, we saw that type of jump and then we saw those numbers hold as different providers started to move back to office. Others who said, "There's no way I'm going back to the office." So obviously, a massive amount of volume to have to adjust with.

Ron Barshop:

So if I as an employer join your platform, my employees are not going to get the same doc or same provider every time. They might get a mid-level in Ohio today and then 20 minutes later, they might get a PCP in Texas, is that correct?

Clinton Philips:

Well, Ron, thanks for asking. The model that Medici now builds for employers says that we build you your own custom care team. So every time you speak to the care team, it's the same doctor, it's the same nurse, it's the same health concierge, it's the same cardiologist.

Clinton Philips:

So, we custom build clinics, health systems, if put a bit of it away and we do them specifically because we didn't like the rotisserie model that we had seen out in the market, where every time you speak to somebody, you get somebody different. We didn't feel there was any way that we could ever drive real behavior change and real quality in care. So our model is for you to have a strong relationship with your care team, even if majority of it is delivered virtually.

Ron Barshop:

So I'm a trucking company with 1,000 employees all over Texas. I now have basically, a specialty group that's been assembled on my company's behalf and I'll get that same PCP, same cardiologists, same mental health specialist every time. Are you offering pretty much all the disciplines or are you restricting yourself to some of them?

Clinton Philips:

We're restricting ourselves. We used and still use 2nd.MD to cover all sub-specialties when needed, but we've started with the more common things. So we huge around primary care. That's really our heartbeat. And just how much can we solve with that how much better than we can make it. We then look at each company's data. So we look at that thousand-person tracking company and we [inaudible 00:09:56].

Clinton Philips:

We really don't like the trend in a muscular spin-up a little team to be able to address those issues. At 1,000 employees, you may be sharing the psychiatrist with three or four other

companies, but to you and your company that feels like a completely dedicated psychiatrist, who will come visit the office, who will come to a Christmas party, who will feel really like the ethos and the culture of the actual company. So we look at the big three.

Clinton Philips:

After primary care, we look at the big three being musculoskeletal lifestyle, mostly diabetes and then behavioral. And we've bought some fantastic things in place with really having ability to train our physicians in a way that they've never been trained before.

Clinton Philips:

And also the opportunity to have these physicians be interconnected, where the primary care doctor knows the cardiologist and doesn't have to kick you out of the system to go to a cardiology system. So, it's really a vertically integrated model that we thinking shows some of the most promise as a foundation for larger health groups in America like, who knows Medicaid, VA and Topica

Ron Barshop:

Are your providers moonlighting with you and others as well or are they exclusive?

Clinton Philips:

They are exclusive. 2nd.MD providers, sub-specialists they are mostly employed at top hospitals, but the primary care provider, the nurse, these are daily catered people. The psychiatrist is dedicated. If you're a smaller company, you might be sharing that specialist with another company.

Clinton Philips:

But they're not moonlighting. We're not competing with the busyness that they have in their practice today. So it allows them to really think around, how do I help this employer in how do we go deep and how do we solve some of their bigger problems?

Ron Barshop:

Let's talk about neuromuscular skeletal. That is a giant problem in America and that prevents a lot of people from doing their best work, when they've got a sore back or carpal tunnel. Are they speaking with a chiro? I'm a big fan of it and I know you obviously, are one and are big fan too. Are they speaking with a physical therapist? Or are they speaking with some other type, like a neuroscientist? What is the doc that's consulting with them on that?

Clinton Philips:

Yes. Something I'm hugely passionate about, obviously, with my background as a chiropractor physiotherapy, is being able to... Having run a clinic here in the US, is the opportunity to see just how much can you help virtually? So, what we have at the center of each of our team, if you're a part of the behavioral team, the central person in the behavioral team is your case manager and they have got behavioral training.

Clinton Philips:

The same way in the musculoskeletal or neuromuscular skeletal, we have somebody who is a physical therapist, most likely, who has a strong physical therapy background, they have access to an orthopedic doctor as needed, they have access to 2nd.MD as needed and most importantly, they've got access to the primary care doctor. So the transition from the primary care doctor to the case manager, physical therapist and back is never been so smooth and so easy, to be able to track, monitor and help this person virtually.

Clinton Philips:

Virtual physical therapy is a very new field, as far as just what can you deliver? How much hours I have to rethink a lot of the care myself, because I was such a hands-on therapist. Everything was hands-on and being able to see what type of outcomes you can deliver virtually has been a fantastic learning curve and shows incredible promise, especially that your cost structure is so much lower than traditional orthopedic care.

Ron Barshop:

Well, you can get a lot done with a rubber band. A large band you'll buy at home and some other stretch bands. If you have a care plan for your neuromuscular skeletal, that gives you exercises to do, I'm sure there's three or four or five, or maybe 10 exercises, someone with a sore back or a torqued out shoulder, or a messed up knee can do before they have to physically go see somebody, is that right?

Clinton Philips:

Absolutely. When we developed the Medici messaging platform, it was amazing how in the app, you have a little folder of your favorite exercises, favorite stretches and it'd be amazing because sometimes when a person is acute, it's a very different exercise that they need to do if they acute.

Clinton Philips:

They've just hurt their back, they're fired up, they're in a lot of pain, they need to get some reassurance that, "You know what? This is probably going to be fine. And here's what I wants you to do. I want you to lie on your back with your knees at a 90 degree angle, I want to I slip an ice pack under your back. And every 20 minutes, I want you to get up and walk. And you're not going to feel walking, but that's how you get better, quick. And he has the data to show that if we can keep you moving, you're going to get better quicker."

Clinton Philips:

And seeing how you can deliver that message in a virtual way, is incredible. Next point, as the person has siding pain, "Here's a stretch, here's a mobilization that will really allow you the opportunity to get some relief by yourself." And often what happens with muscular skeletals, people freak out.

Clinton Philips:

They're like, "Oh my gosh, this pain is terrible. I need to go to the ER. I'm going to need back surgery." That anxiety only feeds it. So much of that can really be directed and prevented. And

then you have the ongoing, "Okay, we've got you past that hurdle. Let's make sure that this never happens again. And here's has a routine, given on what I've watched you do by video, as to how we can make sure that, that never happens again."

Clinton Philips:

And I'm really excited to see... I think our program is still in the early stages of just how good it really can be. And we're not the only people in the space trying to be able to help people get out of pain, without them having to go to a hospital, get a epidural, get an unnecessary MRI for something that can be managed with some smart physical therapy and virtual care.

Ron Barshop:

I want to get back to that, but let's talk about medication adherence. Do you have any kind of a feedback loop to know if they took the meds that your docs and their previous docs prescribed?

Clinton Philips:

We don't. That's a great question, Ron. We've researched all types of smart bottles, smart caps, different things to be able to see hence, the person taking the medication. For us, adherence, from what we can tell in not taking the medication isn't as big a problem as today what we find is that, national data shows that 50% of people who have been diagnosed with diabetes a year later, haven't been treated.

Clinton Philips:

So, our goal is to first get you into a relationship with a primary care doctor, somebody who cares, somebody who follows up with you, somebody who's tracking you holistically and globally. And we see that if we can get you into that relationship, adherence takes care of itself. 2nd.MD had over 98% adherence with what the physicians... The plan that they gave them.

Clinton Philips:

The key to that was that, that person really trusted that physician. And really felt like that person had taken the time to understand their needs. So, we're solving adherence via relationship, but I think there is a follow up and continual feedback loops, some remote patient monitoring, but I think there is a fantastic opportunity. Our system's a young one. We're going to be refining this for decades. So, I think there are some fantastic opportunities around technology-based adherence.

Ron Barshop:

There's also wearables. And wearables are now tracking dozens of different feedback, data exhausts of the patient, their sleep, their stress, their workouts, their movement and so there's a lot of information that can be fed into AI, ultimately, that is going to allow for even better adherence, not only to medication, but to weight loss plan.

Clinton Philips:

Absolutely. We are in a skunkworks project with a company called Health Score that basically, the patient just looks at the app and it takes a video of their face and can detect their blood

pressure, heart rate, stress and we're starting to build some long-term pictures now if a person says, "Hey, where's this stress coming?"

Clinton Philips:

Admissions their BMI and it's pretty revolutionary, but it is a simple, even easier than wearing a watch all day. Is taking 30-second scan and we believe if we can get people to take these scans, we're going to have some really great feedback for them, that they don't have to wait for once a year for a physical to find out if they're doing okay or not, or wait for something to break, but we'll be able to give them real-time information on a daily or weekly basis.

Ron Barshop:

So employers, let's talk about the pay model, are they paying you a monthly subscription rate like DPC or are they paying you a different way?

Clinton Philips:

We've had to be a little creative, because trying to move employers from the fee-for-service model is not easy, especially if you're bigger and this is what you've been doing for forever. So, we have either a PEPM model. So we say, "Okay, based on your data, you need a team of X. So you need physical therapy, cardiology, primary care, navigation, et cetera," put this team together for them.

Clinton Philips:

And then say, "Here is the cost, which you can either pay as a PEPM or you can basically pay this in salary form. So basically, you taking on a team of nine people and here's the salaries." And so the very transparent type of process for them to know exactly what they are getting.

Clinton Philips:

And then, by the way, we have got unbelievable and simple process around imaging. For example, our employers pay $600 fee for any type of MRI, anywhere in the state of Texas. And they've never seen that type of processing. They've seen 700 on one and 4,000 on another. So, we've been able to innovate on pricing in a pretty significant way to make it feel simple and transparent and save money.

Ron Barshop:

Okay. So some are paying monthly, per member per month basis. And some of them are just absorbing the salaries.

Clinton Philips:

Yes. And the per member per month scales, as we know, utilization grows quarterly and so, at each point, once a primary care doctor stops, schedule stops and fill up, we introduce, okay, here's the time to add to the next one, but at the same time, helping them understand that the money that they're paying in fee-for-service is coming down at a faster clip to than with our costs are going up.

Ron Barshop:

Yeah. It's interesting. It seems like a race to the bottom. We had a guest, Brad Younggren, who's the chief medical officer of 98point6, and they're asking... I think it was under $20 per member per month for virtual primary care. It just seemed like you can't make a living doing that, but it seems like there's a lot of offerings from very low amounts for BBC.

Clinton Philips:

I think you are right. One of the reasons we never got involved in the Teledoc top model is that it's very quickly a commodity and all of a sudden you're competing with somebody else, who's going to pay their doctors less. Do you really want to be trying to undercut another company, taking the doctor down from 23 bucks to 22 bucks? Is that the pay you want him to deliver?

Clinton Philips:

So in our model, our margins, while not big, allow us to be able to pay doctors well and appropriately for the quality and the level of care that they give. It always blows my mind in healthcare that a doctor who's one year out of practice and may know nothing and may give a terrible experience, usually gets the exact same rate for [997.2 00:22:56] or whatever they're doing, as somebody who might be 30 years experienced.

Clinton Philips:

Unbelievable expertise, unbelievable care delivery and they get the same rate. In what other world or industry does that happen? With somebody at the top of their game, with huge experience is getting paid what a person who newly graduated might get. Or somebody that's giving terrible customer service would get the same fee as somebody giving unbelievably good and attentive customer service. So, the pricing side is something we think needs just as much innovation as the technology to be able to monitor patients and deliver quality care.

Ron Barshop:

It's a good point. What are your two largest competitors? I'm assuming you all are the largest in the country in virtual primary care. Are there others of your size or are you by far the biggest?

Clinton Philips:

No. I think there's others a lot bigger in... We're not a pure-play virtual primary care player. So I think, Crossover and One Medical have moved to offer virtual primary care. I don't know what percentage of their business that makes up. If they separate the onsite or nearsite care from the virtual primary care.

Clinton Philips:

The company, Accolade, who just acquired 2nd.MD also just invested in buying a virtual primary care. We really see ourselves as a health system. So virtual primary care is our real foundation, but if you're only doing virtual primary care, what we've learned from the big companies, they say, "Listen, we run a great clinic onsite here, but when this person goes off to the hospital, we don't know, that's an abyss. And that person might come back with a $10 million claim and we might never even see that person again."

Clinton Philips:

So it was very important for us knowing the knowledge that we had from the specialty care at 2nd.MD, we knew we had to be able to provide a very seamless bridge to go from primary to specialty and back. And whether you're just trying to get a prescription for a headache or you are facing cancer, we couldn't just be kicking you out of the system as soon as something complex happened.

Ron Barshop:

Well, I can give you some market intelligence. We had both Scott Shreeve and Jay Parkinson of Crossover on our show, in the past year, and they have about a million patients in their virtual primary care stable. So, I think you're substantially larger.

Clinton Philips:

I've been wanting to catch up with Jay. I know that he has just recently left Crossover. So, Voice see him as a real innovator.

Ron Barshop:

He was the innovator. When the Apple phone came out and the internet was brand new and fresh on your phone, he was the very first in New York City to offer virtual primary care and he had a million hits in the first few months. So he was the founder of your world.

Clinton Philips:

And I love that he helped at least float the idea. I used to feel like I was alone saying how much messaging could happen. For example, today in Medici system, every employee gets a single number to text and it doesn't matter what you have going on. You've got a single number that you get to text. And we all know that that person's coming from that company with that number.

Clinton Philips:

And we resolve a tremendous amount of the messaging. And Jay was very early to be able to say, "Hey, look at the complexity and the things that we're starting to manage by messaging," because a lot of doctors were putting their nose up saying that's terrible, until we pointed out that doctors are managing their own family and friends via text.

Ron Barshop:

So, I want to close out the show by asking you some hard numbers. You said that outcomes are measurably better and cost is measurably lower. Do you have some numbers you can put to how many ER visits less, people have on your platform? How many hospital visits they have less? How many medications less? How many specialists visits and surgeries they have less? And what the costs are less?

Clinton Philips:

Ron, In about 90 days, we'll have some... Tracking is not very easy because sometimes you're just relying on the person saying, "Oh yeah, I would've gone to the hospital." So what we actually do now, is we look at two to three years data of an employer before we start. And we

say, "What percentage of your people are going to hospital? What percent of your people are engaging yours visits? All those pieces."

Clinton Philips:

So I wish I had a better answer for you now. What I will tell you is that we guarantee, we are comfortable enough to say that we will save you 11% in our first year, we'll save you 18% in the second year and we will save you 20 to 22% in your third year. And so that's a massive... We're putting our money where our mouth is and putting our fees at risk to say, "If we haven't been able to demonstrate savings on what we're doing, we're going to lose a lot of money on this."

Ron Barshop:

Well, by your third year, you're costing yourself out. In other words, you're free. If you take that 20% of a typical $15,000 spend, you are free. You're not costing them anything.

Clinton Philips:

We say this [inaudible 00:28:34] our costs. So from year one, our promises is that this should never cost you anything you can deliver concierge level care and lower your costs. Your people can feel they are getting care that they only dreamt of and it's costing you less. That is possible. That is very possible.

Clinton Philips:

And the doctors can be happier, as you talk about, and obviously, the patients are better. So we are very excited to be able to measure some of these costs outcomes. I'll tell you that it's very difficult. We've looked at other players in the space to say, "How do you really measure impact?"

Clinton Philips:

Because at 2nd.MD, we learned that we could save your life and get you the right chemotherapy costs. The right chemotherapy the first time around you'd have a far better outcome with your cancer, but we couldn't really prove what it would have cost. If you didn't use us. We could say, "Well, you would have gone on to that medication and that might not have worked and that would have cost this and maybe you might've got really sick and gone to the ER."

Clinton Philips:

So some of those things are not as easy to measure. So now we're taking a, what does it cost your people, your employee and employer cost together? Let's look at what your trend has been. And then let's look at how we start to lower that trend, is the approach we've taken.

Ron Barshop:

So let's say I'm the trucking company with 12 oncology patients. The next year, you can just show, we saved you 20% on that oncology costs from the same number of patients or per patient. So we have to assume that we saved you significant money, but it's also prescriptions. They're taking less prescriptions because they need less meds. Now that they're under a regular care of a doc and they need less ER visits because now they can call it in. And most ER visits don't need to happen. They can handle a lot of it by the phone, I'm sure.

Clinton Philips:

Yes. This very easy to measure. So the next time we talk I'll have some really good numbers on well visits, urgent care visits, but the real costly hospitalizations, the real cost of managing diabetic, those are the things that we really trying to dial in and understand better before we just throw out random numbers.

Clinton Philips:

Because I think the industry, especially employers are very tired of hearing, "Oh, this will save you money." They have taken on dozens of programs and they haven't saved money. And everybody says, "Oh, this will save you money. This is save your money." And they're pretty disappointed that there's been a lot of talk and not really the follow throughs. So we're trying to under promise and over deliver.

Ron Barshop:

It's a good way to end this point. I always appreciate having a Texan on the show because I can understand their accent. So thank you for that.

Clinton Philips:

I love Texas.

Ron Barshop:

And the second thing is, if you have a banner that you can fly overhead and give out one message to the average American, what would that message be?

Clinton Philips:

Is, hope this doesn't get me killed, but your insurance network does not work.

Ron Barshop:

That's true. They know that. And then if people want to reach out to you, how would they find you?

Clinton Philips:

If they want to reach out to suzanne@medici.md. She Organizes my life and can get us in contact.

Ron Barshop:

Clint, thanks for being on the show. We'll get caught up again soon.

Clinton Philips:

Thank you, Ron. I really appreciate it.

Ron Barshop:
Thank you for listening. You want to shake things up. There's two things you can do for us. One

go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing. And leave us a review. It helps our megaphone more than you know. Until next episode.